Limited Access to Hospitals: Crisis in California

by Steven T. Valentine
President, The Camden Group

Hospitals in California are in trouble and it’s going to get worse, much worse. As we witness the deterioration of our hospital delivery system, it becomes obvious that there are deeply rooted structural problems, which are impacting our ability to access services and compromising the financial condition of hospitals. Since 1996, 85 general acute care hospitals in California have closed (refer to Exhibit 1).

Exhibit 1
STATE OF CALIFORNIA
Hospital Inventory 1996-2001

<table>
<thead>
<tr>
<th>Year</th>
<th>All Facilities</th>
<th>General Acute Care Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>617</td>
<td>490</td>
</tr>
<tr>
<td>1997</td>
<td>615</td>
<td>489</td>
</tr>
<tr>
<td>1998</td>
<td>582</td>
<td>476</td>
</tr>
<tr>
<td>1999</td>
<td>515</td>
<td>431</td>
</tr>
<tr>
<td>2000</td>
<td>502</td>
<td>410</td>
</tr>
<tr>
<td>2001</td>
<td>496</td>
<td>405</td>
</tr>
</tbody>
</table>

Source: OSHPD Annual Utilization Reports

According to the California Healthcare Association, hospitals are preparing to spend an estimated $24 billion on state-mandated earthquake compliance. This undertaking will exacerbate their precarious situation. If hospitals must access the bond market to finance earthquake retrofits, poor credit ratings will force them to offer higher interest rates to attract buyers for their bonds or reduce the size of the offering. The result will increase their expenses or worse yet, exacerbate their inability to access the capital markets at all.

The most significant note is the inability of hospitals to generate an adequate income to fund or borrow to pay for the seismic upgrades, let alone the unfunded mandates of HIPAA, quality standards (CPOE, intensivists, hospitalists, RIS, PACS, etc.) or EMTALA and the anemic payment from Medi-Cal. The regulations and operating costs that have beset hospitals include:

▲ Nurse staffing ratios
▲ Uncompensated care
▲ Quality report cards
▲ Poor Medi-Cal reimbursement
▲ Payment for Emergency Department Physician Call Coverage
▲ EMTALA

Continued ➔
The factors contributing to a hospital's poor performance can be directly linked to legislative actions that ostensibly were designed to increase access to health care and improve quality, but are actually causing the opposite. Hospitals do not have the financial resources to continue to provide services while bearing the brunt of California's regulations, which adds more obligations with no funding.

Hospitals are finding that fixing the seismic retrofit requirement does not address the issue of the public's demand for private rooms, an increase in the number of operating rooms and their size, more imaging services, modalities and new technologies on the way (e.g., PET) all of which require more space. Hospitals are also watching as niche operators who open competing surgicenters, imaging centers and specialty hospitals target better paying patients and do not accept Medi-Cal or indigent patients.

As shown in Exhibit 2, in 2002, approximately 41 percent of the 474 hospitals in California lost money from operations. The percentage used to be higher, but those facilities losing money have been closing (refer to Exhibit 1).

### Exhibit 2

| California Hospital Operating Margins 2002 |
|-----------------|-----------------|
| Hospitals With  | Hospitals Number | Hospitals Percent |
| Negative Operating Margin | 192 | 40.5 |
| Positive Operating Margin | 282 | 59.5 |
| Total | 474 | 100.0 |

Source: The Camden Group and OSHPD for year ending 12/31/02.

Hospitals have also struggled as the per capita use has declined significantly since 1988. The introduction of HMOs and their growth, combined with improved case management as a result of Medicare’s shift from cost-based to per case (DRG) payment were catalysts for this decline. The adoption of new technology and procedures that shift more volume to outpatient settings has also impacted hospital utilization. Hospitals and doctors have accomplished exactly what the regulators and employers wanted: reduced utilization of hospitals. It does appear that utilization declines have leveled off and are beginning to increase. (see Exhibit 3).

### Exhibit 3

**California General Acute Care Hospital Utilization 1988-2002**

The factors impacting the leveling off of use rates in California reflect:

- A growing young population, especially of Hispanics
- Aging of the baby boomer population into the years of low inpatient hospitalization (under 65 years of age)
- Reduced length of stay due to improved case management and selective use of hospitalists and intensivists
- Recent declines in commercial HMO enrollment and growth in PPO membership
- A continued effort to use outpatient services in lieu of inpatient hospitalization

Stephen Ralph, President/CEO of Huntington Memorial Hospital, located in Pasadena, California started their master building replacement project in 1990, having spent $150 million on facilities, and is staring at another $100 million for the next patient tower. He says, “We have the money to undertake this project through reserves, limited borrowing, and philanthropy. Without reserves and significant philanthropy we could not afford this project.” This replacement project does not increase capacity. Mr. Ralph worries about how to pay for additional bed capacity to handle the population growth and closure of two nearby hospitals and the pending sale/closure of four other hospitals in his service area.
The legislators and regulators are now seeing the results of their misguided actions: the pending sale of 17 of Tenet’s hospitals located in California, the recent closure of Santa Teresita Hospital, Granada Hills Community Hospital and Santa Paula Memorial Hospital, to mention a few. Numerous other hospitals located in California are in technical default of their bonds or bankruptcy, and face imminent closure or consolidation. While Tenet was the first system to be honest to identify selected hospitals with poor performance (increasing Medi-Cal use, nurse staffing ratios, higher work force) and an accompanying big seismic cost. Watch other health care systems – they face the same problems, we just haven’t heard about it yet.

**Chris Van Gorder**, President and CEO of Scripps Health, a 5-hospital system serving San Diego County, points out that his System faces a retrofit cost of more than $300 million, which means the only way he can pay for this expense is to rebuild his balance sheet, build cash, improve operations, borrow and rely heavily on philanthropy to pay for the projects. He further goes on to say that, “unfunded mandates are slowly killing the hospital industry.” Mr. Van Gorder points out that bankers and Wall Street recognize the seismic retrofit obligation and assign higher risk to hospital borrowers in California, which drives up the cost of borrowing unnecessarily and negatively impacts net income.

Mr. Van Gorder does strongly suggest that State legislators must, at a minimum remove the 2013 deadline for seismic retrofit, and proposes that as hospitals seek approval for major building projects, meet seismic requirements at that time.

The hospitals in California need relief and they need it now. The quick and long-term fix to our rapidly approaching breakdown requires more funding to pay for the unfunded mandates, seismic retrofit and adequate payment for services.
Operations Focus: Optimizing Cardiac Cath Lab Scheduling to Improve Access, Satisfaction and Profit

A recent survey of Southern California hospitals with cardiac catheterization labs reveals a significant increase in late afternoon and early evening utilization due to changing clinical patterns and medical staff office practices. To accommodate this need, many hospitals are creating increased capacity by implementing staggered shifts for their staff and by offering regular procedure time during evening and weekend hours.

While offering extended hours to physicians and their patients for cath lab access might seem like a simple solution to a welcome problem of high demand, several important factors must be managed for this to be successful. In fact, extended hours might seem impossible in situations where consideration must be given to unions, shortages of skilled staff, physician scheduling preferences, and medical staff politics. Yet with some effort, it is possible to effectively manage the process for significant clinical, financial and stakeholder satisfaction gains.

Avoid Scheduling Danger Zones

Three areas are essential to analyze and address as a baseline for improving cath lab access, patient flow and profitability.

1. Review existing patient and staff scheduling policies and practices. Compare your trended performance to benchmarks for volume, turn around and procedure times. Then ask staff, key physicians, the admitting manager and selected physician office managers the following questions:
   a. Are the current policies being adhered to? If not why not?
   b. Are current policies effective? Are staff, physicians and others fully aware of existing policies? Is education needed?
   c. Should existing policies be more strictly enforced?
   d. What short- and long-term changes would they suggest to improve patient flow and scheduling?
   e. Are new or high volume physicians’ requests for cath lab time being met?

   Although rare, finding scheduling solutions sometimes can be as simple as updating existing policies, educating staff and physicians, and tightening up enforcement and compliance.

2. Analyze patient distribution by type and caseload.

   Are most cases scheduled electively, or are they added frequently on the day of the procedure? Physicians with patient schedules that are primarily elective can negotiate block times and start times more easily than physicians with cases that are primarily added on the day of the procedure.

3. Configure scheduling practices to accomplish other related goals. As you focus on efficient scheduling to improve patient and physician access and staff availability, consider what other goals you are attempting to accomplish. For example, physician loyalty can be significantly enhanced by ensuring ease of access, positive staff morale and responsiveness, current equipment and technology, and a culture oriented toward patient satisfaction. It is essential to also take into account the following:
   - Have the other constituents in the process validated the goals and the process?
   - Do admitting and ancillary department policies and practices support an efficient schedule?
   - Are the parties clear on the direction that is needed to minimize costs and maximize efficiencies?
   - Do you have the political will to implement difficult options?

Three Common Obstacles

In addition to meeting the needs of patients, physicians and staff, managers need to address these frequently encountered obstacles to implement an efficient and cost-effective cath lab schedule:

1. Gaps in the schedule: Opening up additional schedule time, in the absence of increased volume and good scheduling practices can create down time for staff and increase cost of the services. Effective patient and staff scheduling practices should anticipate and respond to this issue.

2. Unpredictable start/finish times: Accurate procedure time, by physician, is necessary to plan schedules. Computerized scheduling systems can be valuable tools to analyze this data. Time set aside for procedures should be based on actual performance, not estimated times.

3. Adequate staff resources: Effective utilization of personnel to minimize overtime and call backs is critical to maintain high performance, morale and retention of staff. In balancing patient and physician access, alternative staff schedules may need to be considered, and may actually be preferred by some staff.

Increasing use of cardiac cath labs for diagnostic and interventional procedures will put additional pressure on equipment and staff resources in the future. Flexible solutions in staffing and scheduling arrangements could make the difference in leveraging existing resources to yield greater results in satisfaction levels and patient volume.

For further information on how to configure your staffing, scheduling and other cardiac catheterization lab resources for optimal efficiency and financial performance, please contact Ida Merline at IMerline@theCamdenGroup.com.
The Camden Group has been providing consulting and management services exclusively to the health care field since 1970. With more than 1,000 clients located in 40 states, we serve health care systems, individual hospitals, community non-profit organizations, university medical centers, government-controlled organizations, IPAs, medical groups, health plans, and individual physicians.

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- ▲ Cardiac Surgery Feasibility Study
- ▲ Diagnostic Imaging Center Valuation
- ▲ Master Site Plan Financial Modeling
- ▲ Physician Compensation Fairness Opinions:
  - ED On-Call Rates
  - GI Compensation Assessment
  - Intensivist Contract/Rate Review
  - Orthopedics Recruitment Package
- ▲ Hospital Profit Improvement Plan

 Operations Improvement/Interim Management
- ▲ Advanced Access – Medical Group Appointment Acceleration
- ▲ Billing Office Improvement Plan
- ▲ Cardiac Cath Lab Efficiency Study
- ▲ Emergency Department Analysis
- ▲ Community Clinic Executive Management
- ▲ JCAHO/CMS On-Site Survey Preparation
- ▲ Interim Chief Nursing Officer
- ▲ Surgery Department Interim Management
- ▲ Staffing System Redesign

 Strategy And Business Planning
- ▲ Board Planning Retreats (multiple)
- ▲ Cardiology Services Growth Plan
- ▲ Heart Institute Business Plan
- ▲ Hospital Acquisition
- ▲ Market Share/Service Line Analysis
- ▲ Outpatient Services Growth Strategy
- ▲ Physician Recruitment Needs Assessment
- ▲ Service Line Needs Assessment
- ▲ Strategic Plans: Hospital, Medical Group, IPA
- ▲ Urology Institute Business Planning

 Facilities Planning
- ▲ Ambulatory Surgery Center Planning
- ▲ Bed Need/Capacity Analysis
- ▲ Cancer Center
- ▲ Imaging Centers
- ▲ Master Site Plan

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Bradley G. Malsed

Mr. Malsed is a senior consultant with The Camden Group specializing in health care finance. His experience includes financial modeling, cash flow analysis, financial planning, capital planning, operational budgeting, and business valuations.

Prior to joining The Camden Group, Mr. Malsed was a financial analyst in budget and financial planning at the University of Washington Medical Center. He has also worked with Arthur Andersen’s Valuation Services Group, and then joined KPMG as a senior associate in the Business Process Management Healthcare Practice.

Mr. Malsed received his bachelor’s degree in business administration with a concentration in finance from the University of Washington.

Jill A. Young

Ms. Young is a manager with over 18 years of experience in the health care industry. She is an accomplished medical group administrator with expertise in the development and optimization of practice operations resulting in increased efficiencies, financial performance and customer satisfaction.

She has successfully piloted and implemented Advanced Access in large medical group settings which increased patient satisfaction substantially by providing access to same-day appointments as well as continuity of care. She has planned, coordinated and directed all operational and financial aspects of medical group operations, including entities with annual budgets of $40 million and over 100 staff and management direct reports. She has led the redesign of processes to enhance the efficiency of managed care systems in IPA and medical group settings.

Prior to joining The Camden Group, Ms. Young held administrative leadership positions at HealthCare Partners Medical Group, Kaiser Permanente and Medco Associates, Incorporated. She earned her bachelor of arts degree in mental health from California State University, Northridge.

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